UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

OMONTYS (peginesatide)

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Pharmacy NPI:_____Requested Medication:_____ Strength:_____ Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

---

FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO 855-828-4992

CRITERIA:

- Diagnosis of anemia associated with chronic kidney disease
- Current dialysis therapy
- ≥ 18 years old
- Hemoglobin <10% supported by lab work done within the past 3 months (**FAX COPY OF LAB-WORK**)
- Prescribing authority limited to hematologist, nephrologist, gastroenterologist, and infectious disease specialists, or based upon a consult with one of these specialists.
- Must **NOT** be used for patients diagnosed with cancer; request will be automatically denied

INITIAL AUTHORIZATION: 6 Months

RE-AUTHORIZATION: Current dialysis therapy, hemoglobin < 13 supported by lab data done within the past 3 months **(FAX COPY OF LAB-WORK)**.